First name: ____________________ Last name: ____________________

SECTION D — HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccine administration

Vaccine	Route	Dosage	Lot #	Expiration date
Influenza	intramuscular	0.25mL: 24-36 months 0.5mL: >36 months		
Influenza (intradermal)	intradermal	0.1mL (prefilled)		
Influenza (nasal)	intranasal	0.1mL each nostril		
Influenza (high dose)	intramuscular	0.5mL (prefilled)		
Chicken pox (varicella)	subcutaneous	0.5mL		
Hepatitis A	intramuscular	1mL: Adults ≥19 years 0.5mL: Adolescents ≤ 18 years		
Hepatitis B	intramuscular	1mL: Adults ≥20 years 0.5mL: Adolescents ≤ 19 years		
Hepatitis A/B (Twinrix®)	intramuscular	1mL: Adults ≥18 years		
Human papillomavirus	intramuscular	0.5mL		
Japanese encephalitis	intramuscular	0.5mL		
Meningococcal (meningitis)	intramuscular (subcutaneous – Menomune® only)	0.5mL		
MMR (measles, mumps, rubella)	subcutaneous	0.5mL		
Pneumococcal (Pneumovax®)	intramuscular	0.5mL		
Pneumococcal (Prevnar®)	intramuscular	0.5mL (prefilled)		
Polio	intramuscular	0.5mL		
Rabies	intramuscular	1mL		
Shingles (herpes zoster)	subcutaneous	0.65mL		
Td (tetanus and diphtheria)	intramuscular	0.5mL		
Tdap (tetanus, diphtheria and pertussis)	intramuscular	0.5mL		
Typhoid (live oral)	orally	1 capsule by mouth every other day until all taken		
Typhoid (inactive injectable)	intramuscular	0.5mL		
Yellow fever	subcutaneous	0.5mL		

Needle size	Patient gender/weight
Intramuscular injection is in the deltoid	
⅝‡ to 1 inch needle	Female or male weighing less than 130 lbs
1 to 1½ inch needle	Female 130-200 lbs; male 130-260 lbs
1½ inch needle	Female 200+ lbs; male 260+ lbs
Subcutaneous injection is in the upper arm (posterolateral)	
⅝ inch needle	All patients
Intradermal injection is in the deltoid	
Prefilled syringe	All patients

‡A 5/8 inch needle may be used for patients weighing less than 130 lbs (<60kg) for IM injection in the deltoid muscle only if the subcutaneous tissue is not bunched and the injection is made at a 90-degree angle.

I have verified the immunization(s) that the patient requested meets state, age and vaccine restrictions. Initial here: ________

I have verified the requested immunization is the same as the product prepared. Initial here: ________

I have verified the expiration date of the product is greater than today's date. Initial here: ________

For Zostavax®, MMR II®, Varivax®, YF-Vax®, Menveo®, Imovax® and Rabavert®, I have reconstituted the vaccine following the package insert's instructions. Initial here: ________

For patients younger than 9 years of age requesting the influenza vaccine:

Did you verify if a second dose is needed? ☐ Yes ☐ No

If this is the second dose, have 28 days elapsed since the first dose? ☐ Yes ☐ No

Complete BEFORE vaccine administration

Vaccine	NDC	Dosage	Site of administration (circle site)	VIS published date
			L/R IM/SQ	

Immunizer name (print): ____________ **Immunizer signature:** ____________ **Title:** ____________

If applicable, intern name (print): ____________ **Administration date:** ________ **Date VIS given to patient:** ________

Immunization billing notes section (complete all applicable fields)

Insurance name: ____________________ **Payer ID/BIN:** ____________

Cardholder name: ____________ **Recipient ID:** ____________ **Group ID:** ____________

Notes